

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0036335</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Sparta Terrace</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/99</u> to <u>6/30/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>1501 Melmar Drive</u> <u>Sparta</u> <u>62886</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Randolph</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: (<u>618</u>) <u>443-2122</u> Fax # (<u>618</u>) <u>443-2339</u>		Paid Preparer (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin & Glasser LLP</u> <u>30 South Wacker Drive</u> <u>Chicago, IL 60606-7494</u> (Telephone) <u>(312) 207-2264</u> Fax # (312) 207-2958	
IDPA ID Number: <u>363234108003</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>06/01/90</u>			
Type of Ownership:			
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input checked="" type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
IRS Exemption Code <u>501(c)(3)</u>			
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
<input type="checkbox"/> GOVERNMENTAL			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Michael G. Kaplan</u> Telephone Number: <u>(312) 207-2264</u> <u>Altschuler, Melvoin & Glasser LLP</u> <u>30 South Wacker Drive</u> <u>Chicago, IL 60606-7494</u>			

Please send copies of any desk review or audit adjustments to the above address.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sparta Terrace# 0036335 Report Period Beginning: 7/1/99 Ending: 6/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,856</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,506</u>			<u>5,506</u>	13
14	TOTALS	<u>5,506</u>			<u>5,506</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 94.02%

D. How many bed-hold days during this year were paid by Public Aid?

57 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 06/01/90

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 06/01/90NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒

If YES, enter number

of beds certified N/A and days of care provided 0Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/00 Fiscal Year: 6/30/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Sparta Terrace

0036335

Report Period Beginning:

7/1/99

Ending:

6/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7 **	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	26,010	2,258	840	29,108		29,108		29,108		1
2	Food Purchase		24,388		24,388		24,388	(2,984)	21,404		2
3	Housekeeping		1,844		1,844		1,844		1,844		3
4	Laundry		1,703		1,703		1,703		1,703		4
5	Heat and Other Utilities			9,121	9,121		9,121	43	9,164		5
6	Maintenance	9,790		7,559	17,349		17,349	727	18,076		6
7	Other (specify):*										7
8	TOTAL General Services	35,800	30,193	17,520	83,513		83,513	(2,214)	81,299		8
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	96,383	3,211	2,494	102,088		102,088	288	102,376		10
10a	Therapy			1,248	1,248		1,248		1,248		10a
11	Activities		5,240	196	5,436		5,436	1,213	6,649		11
12	Social Services			1,594	1,594		1,594		1,594		12
13	Nurse Aide Training	5,293	200	1,440	6,933		6,933		6,933		13
14	Program Transportation			2,327	2,327		2,327		2,327		14
15	Other (specify):* Routine Dental			1,075	1,075		1,075		1,075		15
16	TOTAL Health Care and Programs	101,676	8,651	11,574	121,901		121,901	1,501	123,402		16
	C. General Administration										
17	Administrative	38,216		35,985	74,201		74,201	(35,985)	38,216		17
18	Directors Fees							2,716	2,716		18
19	Professional Services			4,173	4,173		4,173	10,218	14,391		19
20	Dues, Fees, Subscriptions & Promotions			1,378	1,378		1,378	249	1,627		20
21	Clerical & General Office Expenses	19,524	4,561	4,318	28,403		28,403	8,661	37,064		21
22	Employee Benefits & Payroll Taxes			23,302	23,302		23,302	23,439	46,741		22
23	Inservice Training & Education			436	436		436	799	1,235		23
24	Travel and Seminar			364	364		364	2,084	2,448		24
25	Other Admin. Staff Transportation			262	262		262	114	376		25
26	Insurance-Prop.Liab.Malpractice							4,306	4,306		26
27	Other (specify):*										27
28	TOTAL General Administration	57,740	4,561	70,218	132,519		132,519	16,601	149,120		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	195,216	43,405	99,312	337,933		337,933	15,888	353,821		29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

STATE OF ILLINOIS

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Facility Name & ID Number Sparta Terrace

#0036335

Report Period Beginning:

7/1/99

Ending:

6/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7 **	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			2,782	2,782		2,782	741	3,523			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			449	449		449	5,230	5,679			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			63,926	63,926		63,926	1,386	65,312			34
35	Rent-Equipment & Vehicles			9,590	9,590		9,590	1,506	11,096			35
36	Other (specify):*											36
37	TOTAL Ownership			76,747	76,747		76,747	8,863	85,610			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			532	532		532		532			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			22,190	22,190		22,190	7,397	29,587			42
43	Other (specify):* Nonallowable costs			152,051	152,051		152,051	(152,051)				43
44	TOTAL Special Cost Centers			174,773	174,773		174,773	(144,654)	30,119			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	195,216	43,405	350,832	589,453		589,453	(119,903)	469,550			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sparta Terrace

0036335

Report Period Beginning:

7/1/99

Ending:

6/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(151,612)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(431)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(98)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(309)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (152,458)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	32,555		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 32,555		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (119,903)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Sparta Terrace

ID# 0036335

Report Period Beginning: 7/1/99

Ending: 6/30/00

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49			49
50			50
51			51
52			52
53			53
54			54
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56			56
57			57
58			58
59			59
60			60
61			61
62			62
63			63
64			64
65			65
66			66
67			67
68			68
69			69
70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	0	90

Facility Name & ID Number Sparta Terrace

0036335

Report Period Beginning: 7/1/99

Ending: 6/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Residential Centers, Inc. - See attached Schedule 7A	100.00%	See attached Related Party Schedule		See attached Related Party Schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Repairs & maintenance	\$	Center for Residential Management, Inc.	**	\$ 184	\$ 184	1
2	V	10	Medical supplies		Center for Residential Management, Inc.	**	288	288	2
3	V	11	Activity programming		Center for Residential Management, Inc.	**	1,142	1,142	3
4	V	17	Management fees	7,906	Center for Residential Management, Inc.	**	7,919	13	4
5	V	18	Board fees		Center for Residential Management, Inc.	**	755	755	5
6	V	19	Professional fees		Center for Residential Management, Inc.	**	1,344	1,344	6
7	V	20	Licenses, dues & subscriptions		Center for Residential Management, Inc.	**	46	46	7
8	V	21	Office supplies & telephone		Center for Residential Management, Inc.	**	3,886	3,886	8
9	V	22	Employee benefits & payroll taxes		Center for Residential Management, Inc.	**	11,512	11,512	9
10	V	23	Inservic travel & education		Center for Residential Management, Inc.	**			10
11	V	24	Travel & seminar		Center for Residential Management, Inc.	**	871	871	11
12	V	25	Vehicle expense		Center for Residential Management, Inc.	**	90	90	12
13	V	26	Vehicle, fire & liability insurance		Center for Residential Management, Inc.	**	57	57	13
14	Total			\$ 7,906			\$ 28,094	\$ * 20,188	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

** Center for Residential Management, Inc. is Residential Centers, Inc.'s parent company.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3	4	5	6	7	8	
Schedule V	Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30 Depreciation	\$	Center for Residential Management, Inc.	**	\$ 315	\$ 315	15
16	V	32 Interest expense		Center for Residential Management, Inc.	**	205	205	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 520	\$ *	520 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

** Center for Residential Management, Inc. is
Residential Centers, Inc.'s parent company.

Facility Name & ID Number Sparta Terrace# 0036335Report Period Beginning: 7/1/99Ending: 6/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Management fees	\$	Residential Centers, Inc.	100.00%	\$ 16,720	\$ 16,720
16	V	18 Board fees		Residential Centers, Inc.	100.00%	1,961	1,961
17	V	19 Professional fees		Residential Centers, Inc.	100.00%	3,646	3,646
18	V	20 Licenses, dues & subscriptions		Residential Centers, Inc.	100.00%	11	11
19	V	21 Office supplies & telephone		Residential Centers, Inc.	100.00%	175	175
20	V	22 Employee benefits & payroll taxes		Residential Centers, Inc.	100.00%	6,632	6,632
21	V	24 Travel & seminar		Residential Centers, Inc.	100.00%	126	126
22	V	26 Vehicle, fire & liability insurance		Residential Centers, Inc.	100.00%	3,880	3,880
23	V	32 Interest expense		Residential Centers, Inc.	100.00%	2,921	2,921
24	V	42 Provider participation fees		Residential Centers, Inc.	100.00%	7,397	7,397
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 43,469	\$ * 43,469

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sparta Terrace# 0036335Report Period Beginning: 7/1/99Ending: 6/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 Utilities	\$	Developmental Services of Illinois, Inc.	**	\$ 43	\$ 43
16	V	6 Repairs & maintenance		Developmental Services of Illinois, Inc.	**	543	543
17	V	11 Activity programming		Developmental Services of Illinois, Inc.	**	71	71
18	V	17 Management fees	52,718	Developmental Services of Illinois, Inc.	**		(52,718)
19	V	19 Professional fees		Developmental Services of Illinois, Inc.	**	5,228	5,228
20	V	20 Licenses, dues & subscriptions		Developmental Services of Illinois, Inc.	**	157	157
21	V	21 Office supplies & telephone		Developmental Services of Illinois, Inc.	**	4,600	4,600
22	V	22 Employee benefits & payroll taxes		Developmental Services of Illinois, Inc.	**	2,346	2,346
23	V	23 Inservice travel & education		Developmental Services of Illinois, Inc.	**	799	799
24	V	24 Travel & seminar		Developmental Services of Illinois, Inc.	**	1,087	1,087
25	V	25 Vehicle expense		Developmental Services of Illinois, Inc.	**	24	24
26	V	26 Vehicle, fire & liability insurance		Developmental Services of Illinois, Inc.	**	369	369
27	V	30 Depreciation		Developmental Services of Illinois, Inc.	**	426	426
28	V	32 Interest expense		Developmental Services of Illinois, Inc.	**	2,511	2,511
29	V	34 Rent		Developmental Services of Illinois, Inc.	**	1,386	1,386
30	V	35 Vehicle lease & equipment rental		Developmental Services of Illinois, Inc.	**	1,506	1,506
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 52,718			\$ 21,096	\$ * (31,622)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

** Developmental Services of Illinois, Inc. is Residential Centers, Inc.'s management company.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Sparta Terrace # 0036335 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Ronald Schroeder	President	Board Member	None	13,520	2 hrs/mtg.		Directors Fees	\$ 280	L18, C8	1
2	Eugene Humphrey	Vice President	Board Member	None	7,330	2 hrs/mtg.		Directors Fees	670	L18, C8	2
3	Edward Childers	Secretary	Board Member	None	13,726	2 hrs/mtg.		Directors Fees	274	L18, C8	3
4	Robert Bauer	Treasurer	Board Member	None	11,023	2 hrs/mtg.		Directors Fees	977	L18, C8	4
5	Orland Bauer	Director	Board Member	None	8,687	2 hrs/mtg.		Directors Fees	113	L18, C8	5
6	Shawn Jeffers	Director	Board Member	None	3,155	2 hrs/mtg.		Directors Fees	45	L18, C8	6
7	Darrell Boehne	Director	Board Member	None	12,643	2 hrs/mtg.		Directors Fees	357	L18, C8	7
8											8
9											9
10											10
11											11
12	See attached Schedule 7A										12
13								TOTAL	\$ 2,716		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sparta Terrace# 0036335

Report Period Beginning:

7/1/99Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Center for Residential Management, Inc.
 Street Address 4239 W. War Memorial Drive, Suite 302
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 685-0595
 Fax Number (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Repairs & maintenance	Bed days available	206,424	20	\$ 6,488	\$	5,856	\$ 184	1
2	10	Medical supplies	Bed days available	206,424	20	10,160		5,856	288	2
3	17	Management fees	Bed days available	206,424	20	279,150		5,856	7,919	3
4	18	Board fees	Bed days available	206,424	20	26,600		5,856	755	4
5	19	Professional fees	Bed days available	206,424	20	47,365		5,856	1,344	5
6	20	Licenses, dues & subscriptions	Bed days available	206,424	20	401		5,856	11	6
7	21	Office supplies & telephone	Bed days available	206,424	20	14,574		5,856	413	7
8	22	Employee benefits & payroll taxes	Bed days available	206,424	20	27,615		5,856	783	8
9	24	Travel & seminar	Bed days available	206,424	20	7,941		5,856	225	9
10	25	Vehicle expense	Bed days available	206,424	20	3,189		5,856	90	10
11	26	Vehicle, fire & liability insurance	Bed days available	206,424	20	2,009		5,856	57	11
12	30	Depreciation	Bed days available	206,424	20	11,103		5,856	315	12
13	32	Interest expense	Bed days available	206,424	20	7,240		5,856	205	13
14										14
15										15
16	6	Repairs & maintenance	Direct method							16
17	11	Activity programming	Direct method						1,142	17
18	20	Licenses, dues & subscriptions	Direct method						35	18
19	21	Office supplies & telephone	Direct method						3,473	19
20	22	Employee benefits & payroll taxes	Direct method						10,729	20
21	24	Travel & seminar	Direct method						646	21
22										22
23										23
24										24
25	TOTALS					\$ 443,835	\$		\$ 28,614	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sparta Terrace# 0036335

Report Period Beginning:

7/1/99Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Residential Centers, Inc.
 Street Address 4239 W. War Memorial Drive, Suite 302
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 685-0595
 Fax Number (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Management fees	Number of beds	193	4	\$ 96,535	\$	16	\$ 16,720	1
2	18	Board fees	Number of beds	193	4	21,800		16	1,961	2
3	19	Professional fees	Number of beds	193	4	43,931		16	3,646	3
4	20	Licenses, dues & subscriptions	Number of beds	193	4	138		16	11	4
5	21	Office supplies & telephone	Number of beds	193	4	2,100		16	175	5
6	24	Travel & seminar	Number of beds	193	4	1,268		16	126	6
7	32	Interest expense	Number of beds	193	4	93,326		16	2,921	7
8	42	Provider participation fees	Number of beds	193	4	101,704		16	7,397	8
9										9
10										10
11	22	Employee benefits & payroll taxes	Direct method						6,632	11
12	26	Vehicle, fire & liability insurance	Direct method						3,880	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 360,802	\$		\$ 43,469	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sparta Terrace# 0036335

Report Period Beginning:

7/1/99Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Developmental Services of Illinois, Inc.
 Street Address 4239 W. War Memorial Drive, Suite 302
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 685-0595
 Fax Number (309) 685-8463

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Bed days available	206,424	20	\$ 1,518	\$	5,856	\$ 43	1
2	6	Repairs & maintenance	Bed days available	206,424	20	19,133		5,856	543	2
3	11	Activity programming	Bed days available	206,424	20	2,500		5,856	71	3
4	19	Professional fees	Bed days available	206,424	20	184,323		5,856	5,228	4
5	20	Licenses, dues & subscriptions	Bed days available	206,424	20	5,518		5,856	157	5
6	21	Office supplies & telephone	Bed days available	206,424	20	162,176		5,856	4,600	6
7	22	Employee benefits & payroll taxes	Bed days available	206,424	20	82,697		5,856	2,346	7
8	23	Inservice travel & education	Bed days available	206,424	20	28,154		5,856	799	8
9	24	Travel & seminar	Bed days available	206,424	20	38,328		5,856	1,087	9
10	25	Vehicle expense	Bed days available	206,424	20	846		5,856	24	10
11	26	Vehicle, fire & liability insurance	Bed days available	206,424	20	13,012		5,856	369	11
12	30	Depreciation	Bed days available	206,424	20	15,000		5,856	426	12
13	32	Interest expense	Bed days available	206,424	20	88,507		5,856	2,511	13
14	34	Rent	Bed days available	206,424	20	48,842		5,856	1,386	14
15	35	Vehicle lease & equipment rental	Bed days available	206,424	20	53,081		5,856	1,506	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 743,635	\$		\$ 21,096	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sparta Terrace# 0036335

Report Period Beginning:

7/1/99Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sparta Terrace# 0036335

Report Period Beginning:

7/1/99Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	NCS Healthcare, Inc.		X	Hardware/software	\$145.00	10/31/98	\$ 5,783	\$ 3,640	09/30/03	0.1429	\$ 326	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$145.00		\$ 5,783	\$ 3,640			\$ 326	9	
	B. Non-Facility Related*												
10							Miscellaneous Interest Expense				2,868	10	
11							Offset Interest Income & Non-allowable Interest Expense				(231)	11	
12							Allocated From Parent & Management Company				2,716	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 5,353	14	
15	TOTALS (line 9+line14)						\$ 5,783	\$ 3,640			\$ 5,679	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Sparta Terrace**# **0036335**

Report Period Beginning:

7/1/99

Ending:

6/30/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	2
3. Under or (over) accrual (line 2 minus line 1).	\$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$ N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

	FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

A. Square Feet:

4,100

B. General Construction Type:

Exterior

Wood with siding

Frame

Wood

Number of Stories

One

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	N/A				1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4									\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Security alarm system		1994	2,045	136	15	136		886	9
10		Carpet		1995	1,301	87	15	87		477	10
11		Replacement of water lines		1995	1,550	103	15	103		491	11
12		Additional water line		1995	1,001	67	15	67		306	12
13		Mixing valve		1998	626	42	15	42		105	13
14		Carpet		1998	1,185	79	15	79		171	14
15		Backflow prevention		1998	1,131	76	15	76		120	15
16		Paint and ceramic tile		1999	827	55	15	55		83	16
17		Second backflow prevention		1999	1,165	78	15	78		90	17
18		Tile		1999	3,116	121	15	121		121	18
19		Shower		1999	1,113	43	15	43		43	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 15,060	\$ 887		\$ 887	\$	\$ 2,893	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 17,626	\$ 1,877	\$ 1,877	\$	5-10	\$ 8,305	37
38	Current Year Purchases	2,150	18	18		10	18	38
39	Fully Depreciated Assets							39
40	Parent Company & Management Allocation			741	741			40
41	TOTALS	\$ 19,776	\$ 1,895	\$ 2,636	\$ 741		\$ 8,323	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42							\$			42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 34,836	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 2,782	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 3,523	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 741	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 11,216	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Community Living Options, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>16</u>	<u>06/01/00</u>	\$ <u>63,926</u>	<u>5</u>	<u>5</u>	3
4	Additions							4
5								5
6	Parent & management company allocations				<u>1,386</u>			6
7	TOTAL		<u>16</u>		\$ <u>65,312</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

N/A

N/A

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 1,853 Description: Copier \$350; Management company allocation \$1,503

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident care	1996 Century Buick	\$ <u>770.00</u>	\$ <u>9,240</u>	17
18					18
19					19
20	Allocated from management company			<u>3</u>	20
21	TOTAL		\$ <u>770.00</u>	\$ <u>9,243</u>	21

10. Effective dates of current rental agreement:

Beginning 06/01/00

Ending 05/31/05

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 06/30/2001 \$ 68,532

13. 06/30/2002 \$ 68,532

14. 06/30/2003 \$ 68,532

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>80</u>
		HOURS PER AIDE <u>40</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	1,440	\$	1,440
2	Books and Supplies		200		200
3	Classroom Wages (a)		5,293		5,293
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	6,933	\$	6,933
10	SUM OF line 9, col. 1 and 2 (e)	\$	6,933		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Emergency Dental Other (specify): Eye Care	L39, C3 L39, C3			5 2	422 110		5 2	422 110	13
14	TOTAL			\$	7	\$ 532	\$	7	\$ 532	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 921)	40,795	40,795	3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	687	687	6
7	Other Prepaid Expenses	33,842	33,842	7
8	Accounts Receivable (owners or related parties)	175,435	175,435	8
9	Other(specify): See attached Schedule 17A	26,135	26,135	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 276,894	\$ 276,894	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	15,060	15,060	15
16	Equipment, at Historical Cost	19,776	19,776	16
17	Accumulated Depreciation (book methods)	(11,216)	(11,216)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 23,620	\$ 23,620	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 300,514	\$ 300,514	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 61,755	\$ 61,755	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,566	10,566	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule 17A	35,269	35,269	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 107,590	\$ 107,590	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,640	3,640	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,640	\$ 3,640	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 111,230	\$ 111,230	46
47	TOTAL EQUITY (page 18, line 24)	\$ 189,284	\$ 189,284	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 300,514	\$ 300,514	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Sparta Terrace
Provider # 0036335
6/30/2000

Schedule XV - Balance Sheet

<u>Line 9-Other assets</u>	<u>After</u>	
	<u>Operating</u>	<u>Consolidation</u>
Prepaid Deposits	15,550	15,550
Due From Third Party	10,585	10,585
Total Other Assets	<u>26,135</u>	<u>26,135</u>

<u>Line 36-Other current liabilities</u>	<u>After</u>	
	<u>Operating</u>	<u>Consolidation</u>
Accrued expense	23,829	23,829
Accrued legal & accounting	3,822	3,822
Accrued participation fees	7,396	7,396
Accrued insurance expense	222	222
Total Current Liabilities	<u>35,269</u>	<u>35,269</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 173,877	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 173,877	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	74,901	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Parent company & management allocation	(59,494)	15
16	Other (describe) (added back in column 7)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 15,407	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 189,284	24 *

Operating entity only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	1	2	3
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 505,122	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 505,122	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education	151,615	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	7,348	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 158,963	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	98	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 98	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	171	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 171	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 664,354	30

	2	3	4
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	83,513	31
32	Health Care	121,901	32
33	General Administration	132,519	33
	B. Capital Expense		
34	Ownership	76,747	34
	C. Ancillary Expense		
35	Special Cost Centers	152,583	35
36	Provider Participation Fee	22,190	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 589,453	40
41	Income before Income Taxes (line 30 minus line 40)**	74,901	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 74,901	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
 A Federal Tax return is filed for the combined divisions of Residential Centers, Inc.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Sparta Terrace**# **0036335**Report Period Beginning: **7/1/99**

Ending:

6/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing				\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	62	62	930	15.00	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	961	961	5,293	5.51	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,936	3,328	26,010	7.82	15
16	Dishwashers					16
17	Maintenance Workers	971	1,004	9,790	9.75	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,766	1,958	31,987	16.34	20
21	Assistant Administrator					21
22	Other Administrative	260	269	6,229	23.16	22
23	Office Manager					23
24	Clerical	721	740	19,524	26.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	13,849	15,217	95,453	6.27	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	21,526	23,539	\$ 195,216 *	\$ 8.29	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 840	L1, C3	35
36	Medical Director	Monthly	1,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	164	L10, C3	39
40	Physical Therapy Consultant	3	180	L10a, C3	40
41	Occupational Therapy Consultant	2	105	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	15	963	L10a, C3	43
44	Activity Consultant	9	1,142	L11, C8	44
45	Social Service Consultant	33	1,594	L12, C3	45
46	Other(specify)				46
47	Psychological Consultant	Monthly	2,330	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	62	\$ 8,518		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses				50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount		
Lisa Tippy	Administrator	0.00%	\$ 31,987	Workers' Compensation Insurance	\$ 6,908	IDPH License Fee	\$ 35		
				Unemployment Compensation Insurance	5,649	Advertising: Employee Recruitment	38		
				FICA Taxes	14,711	Health Care Worker Background Check	36		
				Employee Health Insurance	12,610	(Indicate # of checks performed 5)			
Parent Company Allocation	See Schedule 21A		6,229	Employee Meals	2,984	Illinois Health Care Association	826		
				Illinois Municipal Retirement Fund (IMRF)*		MES Fees	175		
				Employee Morale	2,360	Secretary of State	127		
				Employee Vaccinations	1,519	Miscellaneous Dues and Fees	245		
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)									

* Attach copy of IMRF notifications

****See instructions.**

SEE ACCOUNTANTS' COMPILATION REPORT

Sparta Terrace
IDPH # 0036335
6/30/2000

XIX. Support Schedules

C. Professional Services

	Type	Amount
Total (agree to Schedule V, line 19, column 3)		4,173
Allocated from parent company		
Mangum, Smietanka, & Johnson	Legal	801
Altschuler, Melvoin & Glasser LLP	Accounting	466
American Express Tax & Business Services	Accounting	77
Allocated from management company		
Altschuler, Melvoin & Glasser LLP	Accounting	1,512
American Express Tax & Business Services	Accounting	797
ADP	Payroll	2,589
Health Outcomes	Consulting	330
Allocated from corporation		
Mangum, Smietanka, & Johnson	Legal	1,231
Altschuler, Melvoin & Glasser LLP	Accounting	1,755
American Express Tax & Business Services	Accounting	<u>660</u>
Total (agree to Schedule V, line 19, column 8)		<u><u>14,391</u></u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
2														
3	N/A													
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20		TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sparta Terrace

STATE OF ILLINOIS

0036335

Report Period Beginning:

7/1/99

Ending:

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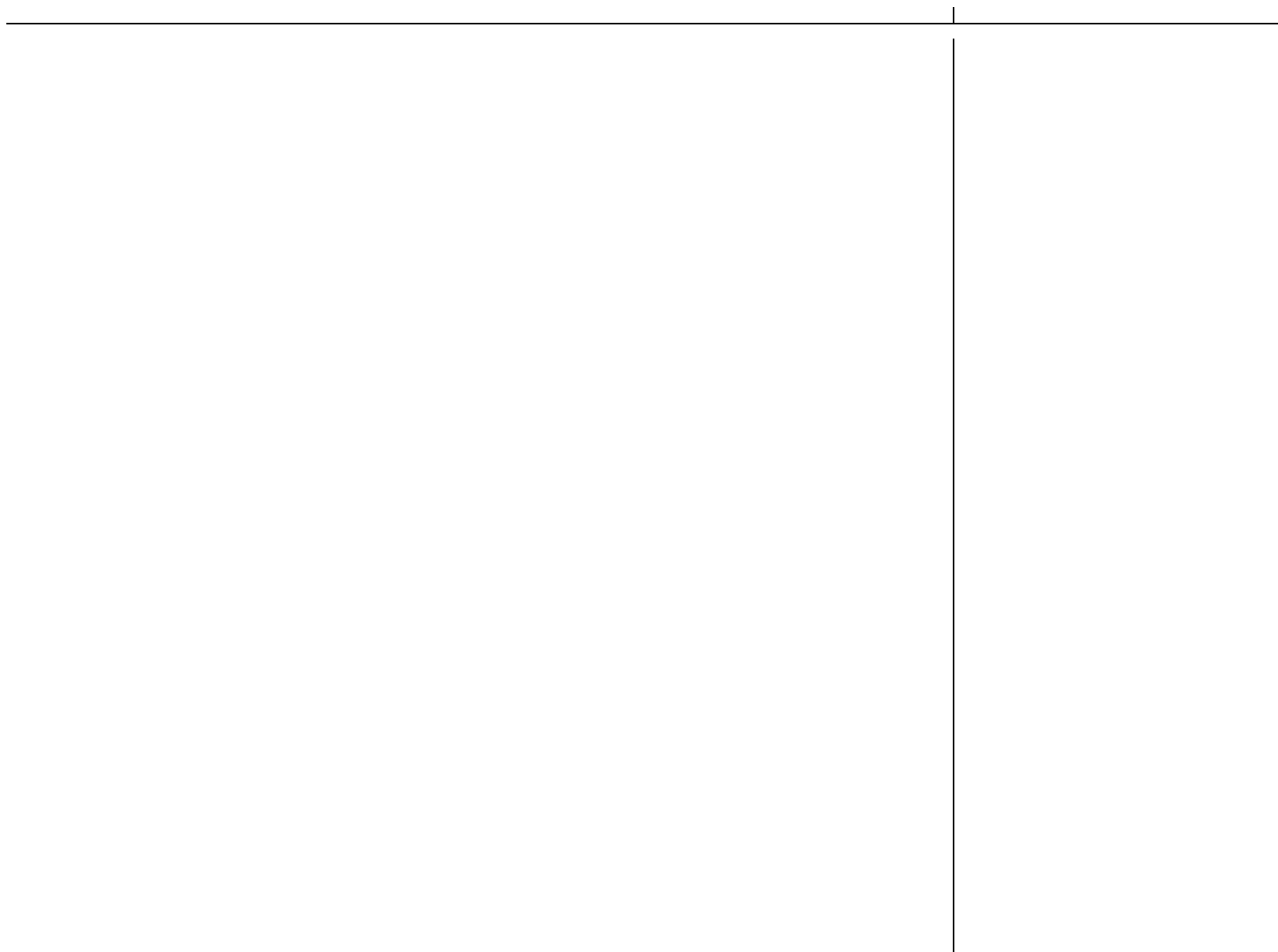
6/30/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association \$826
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 29,587
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 2,984 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 86%
d. Have vehicle usage logs been maintained? Adequate records are maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Altschuler, Melvoin & Glasser LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.



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